

SENT VIA EMAIL OR FAX ON
May/21/2012

Pure Resolutions LLC

An Independent Review Organization
990 Hwy 287 N. Ste. 106 PMB 133
Mansfield, TX 76063
Phone: (817) 405-0870
Fax: (512) 597-0650
Email: manager@pureresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/18/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

RT total knee replacement

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Orthopedic Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Adverse determination after reconsideration notice 04/04/12

Adverse determination notice 03/22/12

Office notes 11/17/11-03/15/12

MRI right knee 01/24/12

Appeal letter 03/28/12

carrier response to IRO 05/08/12

Utilization review request 03/19/12

Utilization review appeal request 03/28/12

Evaluation 11/08/11

Office notes 03/09/12

CT lumbar spine 03/05/12

Physical therapy notes 09/09/11 and 08/30/11

Functional capacity evaluation 07/19/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male whose date of injury is xx/xx/xx. Records indicate he lost his balance and fell down hurting his back, head and right knee. The claimant is noted to have previously had right knee surgery with ACL reconstruction in 1992. MRI right knee dated 01/24/12 revealed evidence of prior ACL allograft with tear, joint effusion, chronic synovitis multiple loose bodies; high grade meniscectomy medial meniscus; irregularity and tear of lateral meniscus, free margin throughout posterior horn complex; postoperative thickening of patella

tendon; grade IV chondromalacia medial knee joint compartment. The claimant was seen on 03/15/12 for follow-up to discuss surgery / total knee replacement. On examination the claimant is noted to be 71 inches tall and 290 lbs. Body mass index is 40.45. Left knee examination is normal. Examination of the right knee is not normal. There is moderate tenderness and pain throughout the knee. There is mild swelling. There is crepitus with rotation of tibia on femur. Medial collateral ligament was unstable with valgus stress. Pivot shift test was negative, anterior drawer was negative, Lachman's was negative, and stable lateral collateral ligament varus stress of knee. There was genu varum deformity. McMurray's was positive referred to medial side of knee joint, and there is pain with compression of patella against femur. The claimant was noted to have failed all conservative management and was recommended to undergo total knee arthroplasty.

A pre-authorization request for right total knee replacement as reviewed and adverse determination recommended per notice dated 03/22/12. It was noted that Official Disability Guidelines requires multiple compartments to support request for total knee arthroplasty. The claimant has had prior ACL repair, medial meniscectomy. Given the claimant is 40 years old with BMI over 40, being morbidly obese with findings in one compartment, he does not meet criteria for total knee arthroplasty.

A reconsideration request for right total knee replacement was non-authorized per notice dated 04/04/12. It was noted that the claimant complains of significant right knee pain. He has been treated conservatively with Synvisc one injection that provided no benefit. MRI of the right knee on 01/24/12 revealed post-operative change with prior ACL allograft with tear noted. There was joint effusion, chronic synovitis and multiple loose bodies. Grade 4 chondromalacia of the medial compartment was reported. X-rays of the right knee were noted to show tricompartmental osteoarthritis, bone on bone, end stage cartilage loss in all three compartments, but no radiology report was provided. It was further noted that the claimant was only with BMI of 38.3. Per Official Disability Guidelines, total knee arthroplasty is indicated in patients who are over 50 years of age and BMI less than 35. Given the current clinical data, medical necessity was not established at this time. The case was discussed with, but no additional pertinent information was provided to change the determination.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

Based on the clinical data provided, the request for right total knee replacement is not supported as medically necessary. The claimant sustained an injury to the right knee, low back and head secondary to a fall on xx/xx/xx. He has a history of previous ACL repair. Right knee MRI performed 01/24/12 revealed post-operative changes with evidence of prior ACL allograft with tear and previous medial meniscectomy. Grade 4 chondromalacia was noted in the medial knee joint compartment. indicates that weight bearing x-rays show tricompartmental osteoarthritis, bone on bone, and end stage cartilage loss in all three compartments of the right knee, but no radiology report was provided. The records indicate that the claimant is with a BMI over 40. According to Official Disability Guidelines, total knee arthroplasty is not supported for patients under 50 years of age and BMI over 35. Consequently medical necessity is not established for right total knee replacement and previous denials are upheld on IRO.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)